TACHC

The Heartbeat of Texas Community Health Centers | **Weekly Wrap-up - June 7, 2013**

In This Issue

Click on the blue header to go to the pertinent section of this email

- **TACHC June CPI Webcast: Cancer Screening-Highlighting Improvement (Part 2)**….For more on this topic, see the Upcoming Events section
- **NACHC-sponsored Training for New Medical Directors Hosted by TACHC**….For more on this topic, see the Upcoming Events section
- **TACHC Clinical Director Institute**….For more on this topic, see the Upcoming Events section
- **83rd Legislative Session Update**….For more on this topic, see Item #1 in the Governance and Finance section
- **TACHC Executive Leadership Initiative**….For more on this topic, see Item #2 in the Governance and Finance section
- **Physician Education Loan Repayment Program (PELRP) Now Accepting Applications Until August 31, 2013!**….For more on this topic, see Item #3 in the Governance and Finance section
- **HHSC State Innovation Models Initiative**….For more on this topic, see Item #4 in the Governance and Finance section
- **New Resource to Help Asian Smokers Quit Tobacco**….For more on this topic, see the Clinical Affairs section
- **TACHC Congratulations to Community Health Development, Inc., South Texas Rural Health Services, Inc., & Los Barrios Unidos Community Clinic for New Hires!**….For more on this topic, see the Recruitment & Retention section
- **TACHCiversaries**….For more on this topic, see Item #1 in the Other News section
- **TACHC Member News**….For more on this topic, see Item #2 in the Other News section

Dental Exam
Gulf Coast Health Center
Port Arthur, TX

Upcoming Events

TACHC June CPI Webcast: Cancer Screening-Highlighting Improvement (Part 2)

June 21, 2013, 9am to 11am

We will review the homework assignment from Part 1 and discuss how centers can leverage this data for improvement. We will also highlight the screening work from other community health centers. To register for this event, click **HERE**. If you have any questions, please contact Verne LaGrega, Clinical Coordinator at TACHC.

NOTE: Registration for all CPI Webcast Trainings is for two webcasts, Parts 1 and 2, at once. If you missed part 1 of the training, you will be able to access a recording of it via the TACHC Community Health Learning Network (CHLN) website.

NACHC-sponsored Training for **New** Medical Directors Hosted by TACHC

June 26-27, 2013; Sheraton Arlington Hotel, 1500 Convention Center Drive, Arlington, Texas 76011

Are you new to your role as Medical Director of your health center? This training will be a foundational and essential building block in your career development, providing core knowledge and competencies that all health center Medical Directors need to function as effective managers, leaders, and advocates for their centers and communities. In addition to providing contextual knowledge regarding the history, political evolution, regulatory expectations, and terminology of the health center movement, course content focuses on developing competency in evolving health care issues such as the patient centered medical home, electronic health records, and meaningful use. For registration and hotel information, click **HERE**. For additional information about the training, contact Dr. Davelyn Eaves Hood, Director of Clinical Affairs at TACHC.

TACHC Clinical Director Institute

June 28-29, 2013; Sheraton Arlington Hotel, 1500 Convention Center Drive, Arlington, Texas 76011

Attention all Chief Medical Officers, Chief Dental Directors, and Behavioral Health Directors, please join your colleagues this year for an interactive network and learning event. Sessions include an update on TACHC Clinical Initiatives, FQHC Billing for Clinical Directors, Better Documentation and Coding, Patient Termination in the Safety Net Setting and UDS from Audit to Submission to Improvement, What Does it Mean for Your Center and Health Home, How Well Do you know your Health Care Community. There will be specialized breakout sessions for the Medical, Behavioral and Dental providers on topics such as: Moving HIV Care into the Primary Care Setting, Quality Metrics in the Dental Setting, Models of Integration that Work, How Do Medical and Dental Providers Complement Each Other and Teaching the Care Team about Screening and Brief Behavioral Health Interventions. For hotel information and to register for the conference, click **HERE**. For additional

	information, contact Dr. Davelyn Eaves Hood, Director of Clinical Affairs at TACHC. Information regarding all upcoming events hosted by TACHC can be found **HERE**.

Governance and Finance

1. 83rd Legislative Session Update: Attached is a summary of bills passed during the 83rd Legislative Session that will impact Health Centers. A special thank you to Shelby Tracy, Policy and Research Coordinator for all of her work.

2. TACHC Executive Leadership Initiative: TACHC has been funded by the Bureau of Primary Health Care (BPHC) to conduct another round of the TACHC Executive Leadership Initiative. This will be the 13th year of this very successful program. We are in the process of recruiting up to seven new teams from community health centers for this year's program (July 2013 through March 2014). The program has been completely restructured to be more focused on specific leadership challenges including employee engagement and change management, provide on-site health center consulting services to support and address individual health center challenges and to support your center's efforts to prepare for and/or maintain PCMH accreditation. This year, we will also be incorporating mid-level management training to support your Executive team's efforts to "push down" effective management and employee engagement strategies throughout your organization. The program has been designed to minimize time away from your center and is heavily subsidized by grant funds to support training costs, on-site leadership consulting, and will cover the majority of team travel costs associated with the three face-to-face learning sessions. Specific information on project design, time commitment, and program costs are attached. If your center is interested in participating in the program, please email or call Jana Blasi, Deputy Director at TACHC.

3. Physician Education Loan Repayment Program (PELRP) Now Accepting Applications Until August 31, 2013: The PELRP provides loan repayment funds to physicians who agree to practice in a Health Professional Shortage Area for at least four years. The Application for Enrollment in the PELRP may be downloaded from the program web page. The priority **deadline** for the initial group of new applications is **August 31, 2013**. If the funds are appropriated for this program, applications will be ranked after the priority deadline, according to current criteria established in the administrative rule (see attached document: *THECB-PELRP.DOCX)*. Any programmatic changes resulting from the passage of new legislation will be updated on the PELRP webpage. If you have any questions, please contact Lesa Moller, Stacy Johnson, or Tamika Lighten at the Texas Higher Education Coordinating Board by phone at (512)427-6366, (512)427-6357, or (512)427-6492 or by e-mail at loanrepaymentprograms@thecb.state.tx.us.

4. HHSC State Innovation Models Initiative: A model design award was granted to HHSC on April 1, 2013, as part of the State Innovation Models initiative to design an innovative payment and delivery system model. The six-month long initiative will conclude September 30, 2013. Under this project, Texas will design innovative multi-payer delivery and payment models that base payment on quality

outcomes. Potential models include:

- Accountable care organizations or shared savings arrangements
- Bundled or episodic payments
- Medical or health homes

To design innovative models, HHSC will:

- Convene public and private payers, providers and other stakeholders through webinars and meetings to develop a common understanding and consensus around the design of an innovative model and determine the elements needed to successfully implement that model, including health information technology infrastructure, billing and claims data, and quality measures
- Research actuarial and financial models and determine policy options
- Design innovative and meaningful payment and delivery models specific to the needs of Texans

All meetings and webinars scheduled for this initiative will be open to the public and details will be posted on this webpage: https://www.hhsc.state.tx.us/hhsc_projects/Innovation/sim.shtml. This is important to all TACHC members and as such we would like you to attend the meetings whenever possible. This may be the platform for a Medicaid ACO. See the attached FAQ for more details. The links for the archived April 19, 2013, Kick-Off Webinar are listed below.

- Presentation (PDF)
- Recording of the webinar (MP4)

Public Regional Meetings: Please note that meeting facility arrangements have not yet been finalized and are subject to change. These meetings are open to the public and will be posted with finalized details on the HHSC public meetings webpage.

Clinical Affairs

New Resource to Help Asian Smokers Quit Tobacco: The Asian Smokers' Quitline is a free nationwide Asian-language smoking cessation service operated by the Moores Cancer Center at the University of California in San Diego, CA. The Quitline offers self-help materials, referral to local programs, one-on-one telephone counseling to quit smoking, and a free two-week starter kit of nicotine patches. Patients can access in-language services using these numbers: Chinese: 1-800-838-8917, Korean: 1-800-556-5564 and Vietnamese: 1-800-778-8440. For more information, click **HERE**.

Recruitment and Retention

TACHC Congratulations to Community Health Development, Inc., South Texas Rural Health Services, Inc., & Los Barrios Unidos Community Clinic for New Hires! Recently, three TACHC candidate referrals have accepted offers of employment from member centers. Dr. Celina Garza accepted an offer from Community Health Development, Inc. for their Dental position, Kila D. Nsamenang accepted an offer from South Texas Rural Health Services, Inc. for their Physician Assistant position, and Dr. Janai M. Okorodudu accepted an offer from Los Barrios Unidos Community Clinic for their Family Medicine position.

Have an opening that you would like us to help you recruit for? Click **HERE** and complete the quick and easy online position profile. Contact April Sartor, Recruitment Dept. Program Assistant at TACHC if you have questions or need assistance.

Other News

1. TACHCiversaries: Please join TACHC in celebrating twelve years of working with and for community health centers for TaSheena Mitchell, Meeting Coordinator; eight years for Todd Radloff, Director of Information Technology; seven years for Cecile Carson, Associate General Counsel & Compliance Officer; two years for Shelby Tracy, Policy and Research Coordinator; and two years for J.J. Martinez, Network Engineer!

2. TACHC Member News: To learn what your fellow health centers are involved in or read news that may affect your health center, click **HERE** for news coverage. We also encourage you to post your news, questions and comments to each other on the TACHC members listserv (members@tachc.org), where only TACHC executives or their designees are recipients.

http://www.hhsc.state.tx.us/hhsc_projects/Innovation/faqs/index.shtml

Frequently Asked Questions: Texas State Innovation Models Initiative

What is the State Innovation Models initiative?

The State Innovation Models initiative is an initiative created by the federal Centers for Medicare & Medicaid Services (CMS) to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

What will the Texas initiative include?

Under this project, Texas will design innovative multi-payer delivery and payment models that move away from a traditional fee-for-service payment system to base payment on quality outcomes. Potential models include:

- Accountable care organizations (ACOs)
- Shared savings arrangements
- Bundled or episodic payments
- Medical or health homes

To design innovative models, HHSC will:

- Convene public and private payers, providers and other stakeholders through webinars and meetings to develop a common understanding and consensus around the design of innovative models and determine the elements needed to successfully implement that model.
- Research actuarial and financial models and determine policy options.
- Design innovative and meaningful payment and delivery models specific to the needs of Texans.

What are the differences between the models under consideration?

Accountable or Integrated Care Models

- Bring together groups providers and at times, other community entities that accept clinical and financial responsibility for a defined population.
- Can be structured as virtual integrated delivery systems— incentivize providers outside a capitated risk contract or salaried practice to provide high quality care without focusing on generating billable transactions.
- Generally involve both down-side and up-side risk.
- Often build off of existing medical/health home.

Shared Savings Arrangements

- Payers and providers share savings in health care costs that accrue as a result of reforms in health care delivery.
- Can vary depending on contracts between payers and providers.
- May stand-alone or be in conjunction with other quality improvement initiatives.
- Commonly included in accountable care organizations.

Medical or Health Homes

- Offer processes and services not ordinarily provided by primary care practices and often not reimbursed under fee for service payment systems.
- Examples include:
  - Expanded access through extended office hours, open scheduling, telephone or e-mail communications.
  - A strong primary care foundation coordinating care across the entire health care system.
  - Use of health information technology, evidence-based medicine and clinical decision-support tools.
  - A multi-disciplinary team-based approach.

Bundled or Episodic Payments

- Reimburse providers based on performance and ability to achieve satisfactory outcomes in the most efficient manner.
- Generally accompanied by other efforts to improve quality and coordination of care.
- Establish aligned payments for most services, using value-based purchasing approaches to reward high-quality, efficient care.

Is this initiative statewide or limited to certain regions?

Because Texas is large and diverse, HHSC is seeking flexibility from CMS to design models specific to a region's needs rather than implementing any one model statewide.

What payers will be involved in the initiative?

CMS requires that models be multi-payer and involve Medicaid or CHIP. CMS expects commercial payer participation and encourages Medicare involvement. CMS also encourages including state employee benefit programs and state insurance exchanges.

Who should become involved in the Texas initiative?

A major goal of the Texas initiative is to convene stakeholders to reach consensus on the gaps in technical knowledge and resources needed to determine how to pay for health care services based on quality rather than quantity. HHSC invites a diverse group of stakeholders—representing payers, providers, consumers, and other health care interests—to participate, including those who:

- Already have fully implemented innovative models (such as large system accountable care organizations, medical/health homes, bundled payment arrangements).

- Started implementing components of an innovative model (such as health technology utilization, strong care coordination, expanding access).
- Are interested in moving toward a quality-based model but are not yet ready.
- May not desire or be ready to implement such a model but want to work towards improving quality of care and containing costs.

What is the timeline for the Texas initiative?

April 1, 2013: Initiative officially began.
May – June 2013: Stakeholder meetings throughout the state to identify and develop design concepts.
June 2013: A statewide survey developed to get information to be used to design innovative models.
August 2013: A conference in Austin; commends accepted on draft model design.
September 2013: Model design will be finalized for submission to CMS.

Does the initiative end in September?

The CMS model design process officially ends September 30, 2013. However, HHSC plans to continue working with stakeholders on innovative models. CMS has indicated that following the model design stage, another opportunity to apply for model testing will become available. No details concerning timing or requirements have yet been released.

How will this initiative address health information technology?

Health information technology is a critical component of this project. HHSC will solicit feedback at the stakeholder meetings and through the online survey to gauge existing infrastructure, evaluate existing needs, and determine what gaps currently exist. This project cannot duplicate funding or resources available through existing initiatives as a variety of electronic health record and health information exchange grants and other opportunities currently are available to providers from the state and federal governments. HHSC plans to work with stakeholders to ensure they are aware of existing opportunities and may be able to assist in determining how to best use technology in designing and implementing an innovative model.

How does this initiative address behavioral health, long-term services and supports, and pharmacy services?

A quality-improvement component focusing on behavioral health, long-term services and supports, or pharmacy could be included in any of the potential innovation models. CMS has not stated that any particular service or provider could not be included in an innovation model. HHSC encourages stakeholders to submit proposals or suggestions, including what aspects would be most beneficial to communities and how payment systems may be structured to improve health outcomes at stakeholder meetings, through the online survey later this year or via email at any time.

Overview of Bills Passed During the 83rd Legislative Session			
Bill #/Tag	**Author/Sponsor/Effective/Caption**	**Summary**	**Impact on centers**
SB 1 Tag: Budget	Author: Williams Sponsor: Pitts Effective 9/1/13 Caption: General Appropriations Bill	**2014-2015 Budget- Selected strategies and riders impacting health centers** **Article II: Department of State Health Services** Strategy B.1.3 Family Planning: $43 million (All State funds. Federal Title X Family Planning funds were awarded to a different entity; those funds no longer pass through the state.). DSHS Rider 91: Replaced $32 million lost in Title X family planning funds with state general revenue funds. Strategy B.1.4 Community Primary Care Services: $126 million ($100 million new funding for the Primary Health Care Expansion for women's health services and $26 million for current Primary Health Care (PHC) Program). Funding of programs will be bid out separately for Women's Health Services. DSHS Rider 82: Prohibits DSHS from contracting with providers in the PHC program that are ineligible from participating in the Texas Women's Health Program (TWHP). (Eligibility for programs starts with application for WHP) DSHS Rider 86: Funding rider for HB 2392 (mental health program for veterans) at $5 million a year. DSHS Rider 89: Unexpended balance authority for PHC funds- gives DSHS the ability to roll over unexpended funds from 2014 to 2015. Also requires that services provided under the PHC Expansion for women include, but are not limited to, the following: preventative health screenings such as breast and cervical cancer screenings, diabetes, cholesterol, hypertension, and STD-HIV screenings; family planning services including contraception; perinatal services; and dental services. **Article II: Health and Human Services Commission** Strategy D.2.3 Texas Women's Health Program: $71 million HHSC Rider 44: Requires HHSC to provide bi-annual reports to the Legislative Budget Board and the governor on the TWHP that includes: • Enrollment levels and utilization by geographic area, delivery system and age • Savings or expenditures in the Medicaid program based on TWHP enrollment • Descriptions of all outreach activities • The total number of providers enrolled in the program Also requires HHSC to make efforts to expand outreach to providers and patients if reports show a reduction in clients or utilization of 10% or more from 2011 levels. Sec. 51: Contingency for Texas Women's Health Program- If the state decides to cease operation of the TWHP, any remaining funds will be transferred to the PHC expansion in DSHS Strategy B.1.4. HHSC Rider 73: Requires HHSC to continue reimbursing FQHCs their PPS rate for up to 3 visits per woman per year in the TWHP program. HHSC Rider 51: Medicaid funding reduction and cost containment- Lists out initiatives HHSC must look at to reduce spending in the Medicaid program. Initiative (10) directs HHSC to reduce Medicaid rates that are above Medicare rates down to the Medicaid rate. While this could impact health centers, FQHC PPS rates were not the intended target of this reduction.	Health centers are poised to receive a substantial amount of funding from the PHC expansion, the TWHP and the family planning program.

		Article II: Special Provisions Relating to All Health and Human Services Agencies Sec. 48: Program of All-inclusive Care for the Elderly (PACE), authorizes up to 3 additional PACE sites with up to 150 participants at each new sites. **Article III: Texas Higher Education Coordinating Board** Strategy D.1.1. Family Practice Residency Program: $5 million (additional funding allocated in HB 1025) Strategy D.1.3 Physician Education Loan Repayment Program (PELRP): $33.8 million THECB Rider 54: Graduate Medical Education Expansion Program, funding for graduate medical education expansion programs created by HB 2550 at $5 million for fiscal year 2014.	
HB 1025 Tag: Budget	Author: Pitts Sponsor: Williams Effective Immediately Caption: Relating to making supplemental appropriations and reductions in appropriations and giving direction and adjustment authority regarding appropriations.	This is a supplemental budget bill that includes funding for Graduate Medical Education and the Family Practice Residency Program. These funds are effective immediately but are to be allocated across the 2 year period after the bill's effective date. Graduate Medical Education Expansion: Allocates $9.25 million for the purpose of expanding first-year residency slots. Family Practice Residency Program: Allocates $7.75 million for the purpose of awarding grants to family residency programs.	**Total allocation for GME programs (SB 1 and HB 1025):** **Family Practice Residency Program= $12.75 million** **GME Expansion= $14.25**
SB 7 Tag: Managed Care	Author: Nelson Sponsor: Raymond Effective 9/1/13 and 1/1/14 Caption: Relating to improving the delivery and quality of certain health and human services, including the delivery and quality of Medicaid acute care services and long-term care services and supports.	SB 7 redesigns the Medicaid delivery system for groups of people currently covered under traditional Medicaid by expanding the managed care model, and makes other related reforms. Article 1: Puts Medicaid recipients with intellectual and developmental disabilities (IDD) in managed care for acute care and long term services and supports (LTSS). Creates an advisory committee to assist DADS with system redesign and requires HHSC to present two reports to the legislature. DADS will develop pilot programs (patient participation voluntary) for capitated reimbursement models to be tested under the new program. Outlines the criteria for pilot program. Puts the IDD population under the STAR+PLUS program- phase one for acute care services (including habilitation and attendant care services) and phase two for their LTSS under the Texas Home Living waiver (TxHmL). Then transitions the ICF-IDD population (Medicaid program for those living in intermediate care facilities) into STAR+PLUS. All patients have the option of staying in their current program rather than moving to managed care, but the individual waivers will only be continued if determined necessary. Article 2: Requires mandatory participation in managed care for all people receiving acute care services. Requires HHSC to study the feasibility of automatically enrolling a person into a managed care plan at the time they are determined eligible for Medicaid, and to implement if deemed feasible. Extends STAR+PLUS to people in nursing homes, creates an advisory committee to assist and outlines a plan for implementation. Creates a mandatory STAR Kids program for children with disabilities (medically dependent children (MDCP) waiver program). Creates a STAR+PLUS quality council to provide input related to all STAR+PLUS populations. Prohibits all MCOs from making across the board cuts to provider rates without prior approval from HHSC. Makes updates and additions to the Medicaid advisory committee and attempts to foster stakeholder input between DADS and HHSC. Article 3: Requires DADS to create and implement an instrument to determine if IDD person is receiving	Health centers should be aware of the move to transition remaining populations covered under traditional Medicaid to a managed care model.

		appropriate range of services based on their functional need. Provides for additional housing supports for the disabled population. DADS will develop specialized training for providers and caregivers for IDD population at risk of institutionalization who need behavioral health services. Article 4-6: Quality-based outcomes and payment provisions for acute care and LTSS. Requires HHSC, to consult with the quality-based payment advisory committee, to establish a clinical improvement program to explore potential ways to improve quality of care and patient outcomes. HHSC to create an incentive program that defaults more patients who do not select an MCO into MCOs that meet quality goals. Requires MCOs to implement quality based payment systems. HHSC to set up an online capability to provide MCOs and providers with performance data. HHSC to pursue and, if appropriate, implement premium rate-setting strategies that encouraged provider payment reform and more efficient service delivery. HHSC to align service areas for different programs when possible. If cost-effective, HHSC to set up a wellness screening program to evaluate Medicaid recipients' risk for health problems. Requires LMHAs to ensure that people suffering serious mental disturbances receive treatment, and updates list of serious mental illnesses LMHAs to treat. Allows HHSC to transfer funds from DADS allocated to STAR+PLUS to the PACE program. Leach Amendment: **Amendment added intended to prohibit HHSC from expanding Medicaid to new populations under the ACA without the approval of the legislature.**	

SB 8 Tag: Fraud and Abuse	Author: Nelson Sponsor: Kolkhorst Effective 9/1/13 Caption: Relating to the provision and delivery of certain health and human services in this state.	Section 1: Requires HHSC to implement a data analysis unit to improve contract management and detect trends and anomalies in the Medicaid/CHIP programs. Unit must provide quarterly updates to governor and legislative offices. Section 2: Prohibits providers from engaging in marketing activities aimed at influencing a Medicaid or CHIP recipient's choice of provider, is targeted at a person because of their enrollment in Medicaid or CHIP or involves unsolicited contact of the person. Providers can still disseminate information at health fairs, radio, TV or through other means that don't directly target individual people. Requires HHSC to set up a process by which providers can submit marketing plans to HHSC for prior approval. Section 3 and 7: Sets up a regional managed care program for the Medicaid Transportation Program and provides details on program requirements. Section 4: Requires HHSC to periodically review the prior authorization and utilization review processes, both in traditional Medicaid and managed care, to determine if they need modification in order to reduce inappropriate use of services. Section 5: Allows for HHSC's office of inspector general to employ up to five peace officers to assist with the detection and investigation of fraud, waste and abuse in the Medicaid program. Section 6: Extends MCOs' use of the state vendor drug formulary until 2018. Section 8-9: Adds additional requirements on licenses for emergency medical services. Section 10: Requires that HHSC revoke a provider's enrollment or deny approval of a provider's enrollment in the Medicaid program if the provider has been excluded from another state or federal program due to fraud or bodily injury to another person. HHSC may reinstate enrollment in certain circumstances. Section 11: Not more than 2 years after national standards for electronic prior authorization are adopted, HHSC must require Medicaid MCOs and PBMs to accept prior authorizations for prescription drug benefits electronically. Section 12: Specifies that a non-physician provider's period of ineligibility to participate in the Medicaid program begins on the date a judgment of liability against them was initially entered by the trial court, rather than the date on which the determination of liability became final after any appeals. Physicians, physician organizations, and nonprofit health corporations become ineligible the date the determination of liability became final. Section 13-15: HHSC to conduct studies related to ambulance and emergency services personnel. Section 16: Requires HHSC to study the feasibility of creating a standardized prescription drug prior authorization form for paper requests.	Targeting fraud, waste and abuse continued to be a priority for legislators this session. While several other related bills were filed, SB 8 was the major fraud, waste and abuse bill passed this session.

SB 58 Tag: Managed Care/ Mental Health	Author: Nelson Sponsor: Zerwas Effective 9/1/13 Caption: Relating to integrating behavioral health and physical health services provided under the Medicaid program using managed care organizations.	Section 1: INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH SERVICES IN MANAGED CARE. Requires HHSC to integrate, to the greatest extent possible, physical and mental health services, including targeted case management, psychiatric rehabilitation and substance abuse services, in a managed care delivery model (does not apply to NorthSTAR program). MCOs contracting under this program should provide a wide array of private and public providers in their network. Creates two pilot programs in two distinct areas to establish medical homes for people with serious emotional disturbances and a chronic physical health problem. DSHS and HHSC must create a Behavioral Health Integration Advisory Committee. Allows for a peer specialist to be included as a benefit, if cost effective. Section 2: COMMUNITY COLLABORATIVES. Allows HHSC to make up to five grants to entities to establish or expand community collaboratives aimed at improving the health of people who are homeless and have a mental illness. Grants will only be awarded in counties with a population of one million or more, and collaboratives must be self-sustaining in 7 years. Outlines acceptable uses of grant funding, priorities of program funding and outcome measures. HHSC must contract with outside entity to determine effectiveness of collaboratives, and must set up a process to reduce funding to those that don't meet objectives. Section 3: MENTAL HEALTH AND SUBSTANCE ABUSE REPORTING SYSTEM. DSHS and HHSC must create and maintain a public reporting system of performance and outcome measures relating to mental health and substance abuse services. The performance and outcome measures will be developed by DSHS, HHSC and the Legislative Budget Board, with input from the public. The system will allow the public to view and compare measures from community centers providing mental health services, managed care pilot programs for mental health services and contractors with the state who provide substance abuse services. HHSC must study the feasibility of maintaining the reporting system and report to legislators. (This section identical to SB 126.) DSHS Rider 90: Funding rider for SB 58 health community collaboratives, allocates $25 million over the biennium for community collaboratives grants.	Health Centers with homeless grants should be interested in this legislation. Health centers should be aware of new MCOs that may be operating in their service areas. Health centers may be able to participate in collaboratives with other community organizations.
SB 61 Tag: Licensure	Author: Nelson Sponsor: Cortez Effective on 9/1/13 Caption: Relating to the licensing and regulation of military physicians who provide voluntary charity health care.	Allows Board of Medical Examiners to issue military limited volunteer licenses to physicians to provide volunteer charity care to patients at clinics treating primarily indigent patients. Care provided must be uncompensated, and physician must be licensed and in good standing, or retired and in good standing, in another state.	Legislation was championed by Charity Clinic in Texas.
SB 63 Tag: General	Author: Nelson Sponsor: Sheffield, JD Effective immediately Caption: Relating to consent to the immunization of certain children.	Allows for a child who is pregnant or who is the parent of a child with custody of that child to consent to their own immunizations. Applies only to immunizations for which the initial dose is recommended to be given before age seven, per the CDC. A provider can rely on written consent from the child that explains the grounds under which they can consent.	

SB 126 Tag: Mental Health	Author: Nelson Sponsor: Davis, J. Effective 9/1/13 Caption: Relating to the creation of a mental health and substance abuse public reporting system.	(Identical to Section 2 of SB 58.) DSHS and HHSC must create and maintain a public reporting system of performance and outcome measures relating to mental health and substance abuse services. The performance and outcome measures will be developed by DSHS, HHSC and the Legislative Budget Board, with input from the public. The system will allow the public to view and compare measures from community centers providing mental health services, managed care pilot programs for mental health services and contractors with the state who provide substance abuse services. HHSC must study the feasibility of maintaining the reporting system and report to legislators.	Some health centers are substance abuse contractors.
SB 127 Tag: General	Author: Nelson Sponsor: King, S. Effective Caption: Relating to the creation of certain funding formulas and policies and to certain public health evaluations by the Department of State Health Services.	Requires DSHS to develop a formula approach to allocating funds to local health departments that takes into consideration population, social determinants of health, disease burden and other factors. DSHS must evaluate the ability of other entities, including private entities, to perform the services instead of local health departments. DSHS must create a policy to allow for flexibility in local health departments' response to disasters or outbreaks.	
SB 160 Tag: Voting	Author: Huffman Sponsor: Miller, R Effective on 9/1/13 Caption: Relating to the identification of a person as an election poll watcher.	Requires election poll watchers to wear identification, as developed by the secretary of state.	
SB 166 Tag: General	Author: Deuell Sponsor: Larson Effective on 9/1/13 Caption: Relating to the use by certain health care providers of electronically readable information from a driver's license or personal identification certificate.	Allows heath care providers to use driver's licenses to pull patient information. Providers can scan licenses and electronically import information into EHRs. Currently, only hospitals are allowed to use this technology but bill opens it up to other provider types.	FQHCs are not explicitly listed out as an eligible provider in the bill, but should be covered under the definition of health care provider.
SB 227 Tag: General	Author: Williams Sponsor: Zerwas Effective 3/1/14 Caption: Relating to the dispensation of aesthetic pharmaceuticals by physicians.	Allows for certain aesthetic pharmaceuticals, including bimatoprost, hydroquinone and tretinoin prescribed by therapeutic optometrists, to be dispensed by the physician. Provides an exception to the rule that all prescriptions must be dispensed by pharmacists. HHSC will develop rules for the process.	May impact centers providing optometry services.

SB 294 Tag: General	Author: Van de Putte Sponsor: Menendez Effective on 9/1/13 Caption: Relating to extending a local behavioral health intervention pilot project.	The Bexar County local behavioral health intervention pilot project, commonly known as Bexar Cares, provides for the diversion of children at risk of being placed in an alternative setting for behavior management to a system of care that includes behavioral health treatment placement for children and youth. SB 294 extends the pilot project, which is currently set to expire September 1, 2013.	
SB 316 Tag: General	Author: Uresti Sponsor: Davis, S. Effective Immediately Caption: Relating to the substitution by a pharmacist of certain opioid analgesic drugs.	The Texas State Board of Pharmacy shall develop a continuing education program regarding opioid drug abuse and the delivery, dispensing, and provision of tamper-resistant opioid drugs. The board by rule may require a pharmacist to satisfy a number of the continuing education hours required of their license through attendance of a program developed under this section.	Centers with pharmacists should be aware of the new training.
SB 348 Tag: Managed Care	Author: Schwertner Sponsor: Kolkhorst Effective immediately Caption: Relating to a utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program.	Directs HHSC to set up a utilization review process for STAR+PLUS MCOs that includes a determination of whether MCOs are appropriately placing members in STAR+PLUS home and community based services and supports program. HHSC shall review at least high risk MCOs each year and all MCOs by the end of FY2015. Expires Sept 1, 2016. Requires HHSC to report utilization review results to the legislature, and allows for recoupment from the MCO but does not hold a provider liable.	
SB 406 Tag: Scope of practice	Author: Nelson Sponsor: Kolkhorst Effective 11/1/13 Caption: Relating to the delegation and supervision of prescriptive authority by physicians to certain advanced practice registered nurses and physician assistants.	Changes how physicians delegate prescriptive authority to advanced practice registered nurses (APRNs) and physician assistants (PAs). Allows APRNs and PAs to prescribe or order drugs and devices, including certain controlled substances, under a physician's supervision. Replaces site-based delegation with practice-based delegation. Requires the use of a prescriptive authority agreement and outlines requirements for the agreement. Places a cap of 7 PAs/APRNs a physician may delegate, but excludes physicians providing services to medically underserved populations from the cap. Among other requirements, agreements must include a quality assurance and improvement plan with procedures for chart review and periodic in-person meetings. Board must maintain an online database of physicians, PAs and APRNs which have executed prescriptive authority agreements. Entering into an agreement does not hold a physician liable for the act of a PA/APRN unless the physician feels the PA/APRN lacked competency to perform the act. Requires MCOs to treat PAs/APRNs in the same manner as physicians in regards to selection and assignment as a primary care provider, inclusion as a primary care provider in the MCO's network, and inclusion in provider directories.	This bill should improve the ability for physicians at health centers to delegate authority to midlevel providers. The bill removes the requirement that the supervising physician be on site every 10 days and allows a physician to delegate authority to a larger number of PAs/APRNs. These changes should be particularly helpful to centers located in rural areas.

SB 495 Tag: General	Author: Huffman Sponsor: Walle Effective 9/1/13 Caption: Relating to the creation of a task force to study maternal mortality and severe maternal morbidity.	Creates a maternal mortality and morbidity task force to study cases of pregnancy-related deaths and trends in severe maternal morbidity and make recommendations on how to reduce their incidence in Texas. Includes privacy provisions for patients and providers in studied cases, and allows DSHS to create a database of de-identified information. The task force must provide a report to the legislature every even numbered year.	
SB 644 Tag: Managed Care	Author: Huffman Sponsor: Zerwas Effective 9/1/13 Caption: Relating to the creation of a standard request form for prior authorization of prescription drug benefits.	Requires HHCS to develop a standard form for requesting prior authorizations for prescription drug benefits. All insurers, including Medicaid and CHIP MCOs, must use this form for any required authorizations for drug benefits. The form must be made available online and HHSC must develop penalties for insurers that do not accept the form. Within 2 years after the national standards for prior authorization forms are adopted, health insurers must use electronic forms when requested by a provider. Creates an advisory committee to assist HHSC with the development of the prior authorization form. After 2 year anniversary of the form, HHSC must reconvene the advisory committee to consider any necessary updates to the form. The form must be created by 1/1/15. (Similar to SB 1216 which creates a standardized form for prior authorization of health care services.)	Several bills were passed this session with the goal of reducing administrative burdens on health care providers.
SB 746 Tag: Fraud and abuse	Author: Nelson Sponsor: Kolkhorst Effective 9/1/13 Caption: Relating to unlawful acts against and criminal offenses involving the Medicaid program.	Adds conspiring to defraud the Medicaid program as an offense and makes other changes to law related to fraud and abuse in the Medicaid program.	Many bills were passed this session that were aimed at increasing oversight and prosecution of fraud and abuse in the Medicaid program.
SB 869	Author: Van de Putte Sponsor: Zedler Effective Immediately Caption: Relating to the regulation of the practice of pharmacy.	Provides authority to the Texas Board of Pharmacy to regulate pharmacy technician trainees. Sets up requirements for the pharmacy technician trainee registration process.	Centers with pharmacy technicians should remain informed on requirements.
SB 872 Tag: General	Author: Deuell Sponsor: Coleman Effective Immediately Caption: Relating to county expenditures for certain health care services.	Clarifies that a county may credit an intergovernmental transfer (IGT) of funds associated with an 1115 waiver project toward the county's eligibility for state assistance under the county indigent program. Counties may credit IGT funds of up to 4% of the counties general revenue levy in any state fiscal year if the commissioners court determines that the 1115 waiver project, the IGT funds are supporting, fulfills the county's obligation to provide indigent health care. (Counties must spend 8% of their total general revenue on indigent care before qualifying for state assistance.)	Whether or not IGT funds would count toward a county's 8% spending on indigent care was a question that came up frequently when counties were determining whether or not to participate in DSRIP projects. This clarifies that IGT funds will count toward that threshold, but only up to 4% of the county general revenue.

SB 945 Tag: General	Author: Nelson Sponsor: Davis, S Effective 1/1/2014 Caption: Relating to the identification requirements of certain health care providers associated with a hospital.	Requires providers providing direct care at hospitals to wear a photo ID badge, with the provider's name, the hospital name and the provider's type of license.	Health center providers who follow patients to the hospital should be advised of the new requirement.
SB 949 Tag: Licensure	Author: Nelson Sponsor: Sheffield, J.D. Effective Immediately Caption: Relating to the definition of license holder in the Medical Practice Act.	Currently, an applicant to practice medicine in Texas must pass each part of the examination within 7 years. SB 949 exempts applicants who are licensed in good standing in another state, have been licensed for at least 5 years, have never had an disciplinary actions against their license in another state, and who will practice in a MUA or a health manpower shortage area from the time frame requirement. The medical board will develop a process to ensure an applicant practices in one of those areas. Removes the requirement that non-citizen, non-legal permanent resident applicants practice for at least 3 years in a HPSA or MUA.	
SB 978 Tag: General	Author: Deuell Sponsor: Sarah, D. Effective 9/1/13 Caption: Relating to regulation by the Texas Medical Board of local anesthesia and peripheral nerve blocks administered in an outpatient setting.	Subjects the use of local anesthesia to regulation by the medical board when 50% or more of the recommended maximum safe dosage per outpatient visit is administered.	May impact centers that provide local anesthesia.
SB 993 Tag: General	Author: Deuell Sponsor: King, S. Effective Immediately Caption: Relating to the creation of the Texas Nonprofit Council to assist with faith- and community-based initiatives.	Renames the Task Force on Improving Relations with Nonprofits as the Texas Nonprofit Council. SB 993 also changes the council's membership and duties, and makes the council subject to the Texas Sunset Act. Requires the council to coordinate with the interagency coordinating group to make recommendations for improving contracting relationships between state agencies and faith- and community-based organizations. Requires reporting to legislative committees every other year.	

SB 1057 Tag: Health care reform	Author: Nelson Sponsor: Zerwas Effective Immediately Caption: Relating to information about private health care insurance coverage and the health insurance exchange for individuals applying for certain Department of State Health Services programs and services.	Requires a patient or a patient's legal representative to attest, through a form created by DSHS, that the patient is not eligible for coverage of a benefit through private insurance or the health insurance exchange before accessing coverage for that benefit through a DSHS program (e.g. PHC program, Family Planning, etc.). Allows for exceptions in cases of emergency. Rules will be promulgated to implement this new requirement. Requires DSHS to provide information on health insurance exchange coverage and subsidies available to any person applying for health or mental health coverage through a DSHS program who is over 100% FPL. DSHS may develop these educational materials in house.	This bill intends to ensure that state programs funded with state general revenue are the provider of last resort after Medicaid/CHIP, the Health Insurance Marketplace and other programs that include federal funds. All health centers should be aware of this new requirement. TACHC will provide updates as the rules are promulgated and the form is developed.
SB 1106 Tag: Pharmacy	Author: Schwertner Sponsor: Davis, J. Effective 9/1/13 and 3/1/14 Caption: Relating to the use of maximum allowable cost lists under a Medicaid managed care pharmacy benefit plan.	Amends the Government Code to provide requirements related to a maximum allowable cost list to which managed care organizations or pharmacy benefit managers must adhere: 1) Before placing a drug on a maximum allowable cost list, the health plan or pharmacy benefit manager must ensure that the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, or other nationally recognized reference; and the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete. 2) They must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider. 3) They must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing. 4) They must use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Orange Book. 5) They must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace. In addition, the bill requires health plans and pharmacy benefit managers to provide a procedure under which network pharmacy providers may challenge a listed maximum allowable cost price for a drug.	

SB 1150 Tag: Managed care	Author: Hinojosa Sponsor: Guerra Effective 9/1/13 Caption: Relating to a provider protection plan that ensures efficiency and reduces administrative burdens on providers participating in a Medicaid managed care model or arrangement.	Requires HHSC to develop a provider protection plan aimed at reducing administrative burdens and ensuring efficiency in enrollment and reimbursement for providers participating in Medicaid managed care. Components of the plan will be incorporated into state contracts with MCOs. Plan must include provisions for prompt payment and proper reimbursement of claims, adequate provider networks, prompt credentialing processes, uniform standards for prior authorizations, electronic processes, provider retention rates in MCO networks, the creation of a workgroup to analyze these issues, and any other topic HHSC determines appropriate. Plan must be completed no later than 9/1/14.	This bill is aimed at alleviating administrative burdens in the Medicaid managed care program. Health centers report ongoing issues related to participation in managed care; the provider protection plan created by this bill may help reduce some of those persistent issues.
SB 1175 Tag: Medicaid	Author: Deuell Sponsor: Guillen Effective Immediately Caption: Relating to the establishment of a reuse program for durable medical equipment provided to recipients under the Medicaid program.	If determined cost-effective, HHSC will create, by rule, a program to reuse DME in the Medicaid program. The program must be optional for patients and reused equipment must meet functionality and sanitation standards.	Health centers may participate in the program created by the Commission.
SB 1185 Tag: Mental health	Author: Huffman Sponsor: Thompson, S. Effective Immediately Caption: Relating to the creation of a mental health jail diversion pilot program.	Creates a mental health jail diversion pilot program in Harris County. DSHS, in cooperation with the Harris County judge, will create a program to reduce recidivism among persons with mental illness. The pilot must include the following elements: 1) low caseload management; 2) multilevel residential services; and 3) easy access to integrated health, mental health, chemical dependency services, benefits acquisition services, and multiple rehabilitation services. DSHS Rider 94: Funding rider for SB 1182, jail diversion program for Harris County, of $5 million a year.	May be opportunities for Houston centers to participate.
SB 1216 Tag: General	Author: Eltife Sponsor: Davis, S. Effective 9/1/13 Caption: Relating to the creation of a standard request form for prior authorization of health care services.	Requires HHSC to create a single form to be used for requesting the prior authorization of health care services. All insurers, including Medicaid and CHIP MCOs, must accept this form, and it must be made available online. Within 2 years after the national standards for prior authorization forms are adopted, health insurers must use electronic forms when a provider requests. Paper requests will continue to use the form created under this bill. Creates an advisory committee to assist HHSC with the development of the prior authorization form. Form must be created by 1/1/15. (Similar to SB 644 which creates a standard form for prior authorization of prescription drug benefits.)	This bill is aimed at reducing administrative burdens on providers operating in the managed care environment. The bill may help streamline the proper authorization process between private insurers and Medicaid and CHIP MCOs.

SB 1484 Tag: General	Author: Watson Sponsor: Gonzales, L. Effective 9/1/13 Caption: Relating to health benefit plan coverage for enrollees diagnosed with autism spectrum disorder.	Current insurance law requires coverage of autism up to 10 years of age. SB 1484 requires that if a child was diagnosed with autism before the child's 10th birthday, the plan would provide coverage of generally recognized services without consideration of the child's age. The plan would not be required to provide coverage beyond $36,000 per year for enrollees 10 years of age and older. Exempts plans if the coverage is in excess of what is required in the essential health benefit package in the health insurance exchange.	
SB 1542 Tag: Medicaid	Author: Van de Putte Sponsor: Zerwas Effective Immediately Caption: Relating to clinical initiatives to improve the quality of care and cost-effectiveness of the Medicaid program.	Requires HHSC to develop and implement a Medicaid quality improvement process by which the Commission will solicit suggestions on how to improve quality of care and cost effectiveness in Medicaid, conduct a preliminary review of suggestions, and select and analyze certain suggestions. HHSC may accept suggestions from legislators, commissioners of HHSC agencies and certain advisory committees. Outlines 2 required initiatives- one for hospital treatment of severe sepsis and septicemia and another that would authorize the Medicaid program to provide blood-based allergy testing for patients with persistent asthma. Sets up an evaluation process for selected initiatives, which includes a 30 day public comment period. Also sets up an analysis review process and requires final reports. Requires HHSC to maintain a website with this information. Allows HHSC to implement initiatives that are found to be cost effective and improve quality of care. Allows for HHSC to create recommendation to the legislature if a selected initiative requires a change in law.	
SB 1623 Tag: General	Author: Hinojosa Sponsor: Guerra Effective Immediately Caption: Relating to districts in certain counties located on the Texas-Mexico border and amending Chapter 288 of the Health and Safety Code.	Allows for the creation of a county health care funding district in Hidalgo, Webb and Cameron counties. Creates a district local provider participation fund to be used to provide IGT funding for the 1115 waiver, subsidize indigent care programs and provide certain funding to hospitals. Sets up mandatory payments for institutional providers in the district.	Centers in these counties should be aware of these changes.

SB 1795 Tag: Health care reform	Author: Watson Sponsor: Guillen Effective 9/1/13 Caption: Relating to the regulation of navigators for health benefit exchanges.	Gives HHSC the authority to regulate Navigators (persons tasked with helping patients enroll in Medicaid, CHIP and the health insurance exchange under the ACA) if HHSC determines it necessary. Clarifies that Navigators do not need any type of state license to perform their function. HHSC will adopt rules to implement this act and federal law. HHSC shall determine whether federal regulations are sufficient in ensuring that Navigators fulfill their function. If found they are not sufficient, HHSC will make a good faith effort to work with the federal government to propose improvements in the federal standards. If standards are still insufficient, HHSC will promulgate regulations at the state level to ensure Navigators can perform their duties. Navigators may not have had a professional license suspended, may not have been subject to a disciplinary action by a financial or insurance regulator, and may not have been convicted of a felony. HHSC must maintain a list of Navigators in the state and may develop a registration process to ensure that the requirements listed above are met. SB 1795 puts specific limitations on advertising permitted by Navigators, prohibits compensation by health plans, and allows HHSC to create additional Navigator trainings if deemed necessary. Specifies that Navigators may not act as insurance agents and outlines prohibited activities.	Centers that employ Navigators should be aware of the state regulations.
SB 1803 Tag: Fraud and abuse	Author: Huffman Sponsor: Kolkhorst Effective 9/1/13 Caption: Relating to the Office of the Inspector General.	Clarifies procedures for Office of Inspector General (OIG) investigations of Medicaid fraud and abuse and the provider appeals process following determinations of credible allegations of fraud. For payment holds placed on providers following the finding of a credible allegation of fraud must, providers must be given specific information on the basis of the hold and the provider's due process rights. Changes timeframe a provider has for requesting an expedited hearing and timeframe for initial hearing and informal resolution meetings. Requires the OIG to employ medical and dental directors who are familiar with the Medicaid program. Outlines processes for preliminary investigations, recoupment and appeals.	
HB 595 Tag: General	Author: Kolkhorst Sponsor: Nelson Effective 9/1/13 Caption: Relating to the repeal of certain health programs and councils, to the review of certain health programs, panels, councils, systems, foundations, centers, committees, and divisions under the Texas Sunset Act.	Repeals 7 chapters of the Health and Safety Code and their associated programs, including Agent Orange, lice control for minors, tertiary medical care and the Border Health Foundation. These programs have not been funded or have received limited funding in recent biennia. Moves property, leases, obligations, etc. of repealed programs to DSHS. Also repeals Government Code, Sec. 533.005(a-1). This would allow Medicaid managed care organizations and pharmacy benefit managers to continue using the state's preferred drug plan and state formulary.	
HB 658 Tag: Fraud and abuse	Author: Sheets Sponsor: Watson Effective 9/1/13 Caption: Relating to interest on damages subject to Medicare subrogation.	Currently, in Medicare subrogation cases, defendants must wait for their recovery demand letter from CMS before making a payment on their judgment. Interest accrues during this period of waiting, which can be lengthy and is completely out of the control of the defendant. This bill provides that interest does not accrue until after the recovery demand letter has been issued and no interest must be paid if the defendant pays the full amount within 31 days of receiving the letter.	

HB 740 Tag: General	Author: Crownover Sponsor: Deuell Effective 9/1/13 Caption: Relating to newborn screening for congenital heart defects.	Requires that providers at hospitals and other birthing facilities screen newborns for critical congenital heart disease. Updates the resource for national newborn screening standards the Department must use to determine which conditions newborns must be screened for. The Department must create the congenital heart disease test providers must use, and lists certain exceptions. Allows a physician to delegate screening to properly training health care provider working under the supervision of the physician. Updates required membership and duties of the Newborn Screening Advisory Committee.	Health centers providing obstetrical care should be aware of the new screening requirements.
HB 746 Tag: General	Author: Ashby Sponsor: Schwertner Effective 9/1/13 Caption: Relating to allowing health care providers to provide services across state lines in catastrophic circumstances.	Allows for health practitioners licensed in good standing in another state to provide volunteer health services in Texas during a disaster or catastrophic event while an emergency declaration is in effect. The volunteer health practitioner must register with DSHS and undergo a background check prior to being authorized to perform volunteer services.	This bill is intended to ease the process by which out of state providers may provide care during emergency situations. Some centers faced administrative obstacles to bringing on out of state providers temporarily during evacuations related to Hurricanes Katrina and Ike. This bill should improve that process.
HB 748 Tag: General	Author: Raymond Sponsor: Nelson Effective immediately Caption: Relating to a waiver allowing the Department of Family and Protective Services to use certain federal funds to test innovation strategies in child welfare programs.	Directs DFPS to pursue a federal waiver as authorized by the Child and Family Services Improvement and Innovation Act (Pub. L. No. 112-34), to allow the department to use federal funds available under Title IV-E, Social Security Act (42 U.S.C. Section 670 et seq.), to conduct demonstration projects. The goal of the waiver is to improve the wellbeing of children in foster care, reducing the reentry of children into foster care, and promoting successful transitions from foster care to adulthood.	
HB 808 Tag: Licensure	Author: Zerwas Sponsor: Deuell Effective 9/1/13 Caption: Relating to the authority of a psychologist to delegate the provision of certain care to a person under the psychologist's supervision, including a person training to become a psychologist.	Allows licensed psychologists to delegate tests and services to temporarily, provisionally, and newly licensed psychologists not yet eligible for managed care panels. The delegating psychologist retains responsibility for the patient's care and billing can be done under their number. Patients must be informed of the delegating.	Centers with Behavioral Health Program, please pay attention.

HB 1023 Tag: Mental health	Author: Burkett Sponsor: Nelson Effective Immediately Caption: Relating to the creation of a task force to investigate and make recommendations regarding mental health workforce shortages.	Directs HHSC to use existing data to create a report providing recommendations regarding mental health workforce shortages in the state. The report must include specific recommendations to alleviate workforce shortages, an assessment of the feasibility of implementing each recommendation, estimated costs and benefits, and any legislative action needed to implement.	
HB 1205 Tag: General	Author: Parker Sponsor: Carona Effective 9/1/13 Caption: Relating to the offense of failure to report abuse or neglect of a child.	Strengthens and clarifies the requirements for professionals (including doctors and other health care providers) to report child abuse and neglect. Makes it a state jail felony to attempt to conceal abuse or neglect.	
HB 1358 Tag: Pharmacy	Author: Hunter Sponsor: Van de Putte Effective 9/1/13 Caption: Relating to procedures for certain audits of pharmacists and pharmacies.	Outlines procedures for audits of pharmacies by health plans and pharmacy benefit managers. Provides protections for pharmacies. Does not apply to Medicaid, CHIP or Medicare Advantage Plans.	
HB 1491 Tag: Licensure	Author: Branch Sponsor: Williams Effective Immediately Caption: Relating to the temporary licensing of a dentist who performs voluntary charity care.	Allows for certain dentists to get temporary licenses to perform charity care. Dentists must be licensed in good standing and practicing in another state or must have practiced within the last two years at the time of applying for the temporary license. Dentists can only perform charity care and only within the geographic bounds and timeframe specified in the license.	Centers may be able to take advantage of this change and use volunteer dentists in certain circumstances.
HB 1605 Tag: General	Author: Davis, S. Sponsor: Huffman Effective 9/1/13 Caption: Relating to the establishment of a pilot program in Harris County to provide maternity care management to certain women enrolled in the Medicaid managed care program.	Creates a pregnancy medical home pilot program in Harris County to provide coordinated care to pregnant Medicaid recipients. The pilot must include multiple providers in one health home, screen patients for risk level, establish a pregnancy care plan for each participant, and follow participants throughout pregnancy. HHSC must report effectiveness to legislature and recommend continuance by 9/1/15.	Houston area health centers may be eligible to participate in the pilot.

HB 1803 Tag: Licensure	Author: Callegari Sponsor: Huffman Effective 1/1/14 Caption: Relating to the renewal of a controlled substance registration by physicians.	Requires that a physician's controlled substance permit be valid for at least two years and expire on the same date as the physician's registration permit with the Medical Board. Allows for a $50 registration fee for physicians, and registration can be done electronically through the Medical Board, rather than through the DPS as currently required. Notices must be sent to physicians 90 days before the expiration of their permits.	This bill is intended to streamline the process physicians must go through to update their controlled substance permit.
HB 2392 Tag: Mental health	Author: Menendez Sponsor: Van de Putte Effective 9/1/13 Caption: Relating to the mental health program for veterans.	Directs the DSHS to develop and implement a mental health program for veterans. Emphasizes peer-to-peer counseling and the use of volunteers. Funded through a budget rider, DSHS may make grants to regional and local organizations for the delivery of these services. Requires DSHS to submit a report to the governor and legislature that includes data on the number of vets served, effectiveness and recommendations for improvement. Repeals current program (Sec. 1001.076 HAS).	May be opportunities for FQHCs to collaborate with other community organizations to operate program.
HB 2550 Tag: Medical education	Author: Patrick Sponsor: Zaffirini Effective 9/1/13 Caption: Relating to the consolidation of the Higher Education Enrollment Assistance Program and the Higher Education Assistance Plan and the transfer of certain enrollment assistance duties to institutions of higher education.	<u>GME RESIDENCY EXPANSION</u>- Creates one-time planning grants for planning new first-year residency positions to entities that have never had a program and that are eligible for Medicare funding of GME. Those entities will then receive additional funds to continue the residency program. Provides for grants to existing GME programs that have unfilled first-year positions and to existing programs to increase the number of first-year slots available. Stipulates that if there is not enough money to fund all eligible programs, priority should be given to primary care or other critical shortage areas. After FY 2016, if there is more money than applicants, funds may be distributed to support residents who have completed at least 3 years of residency and whose program is in a field that the state has less than 80% of the national average per 100,000 people. <u>PRIMARY CARE INNOVATION PROGRAM</u>- Establishes a grant program for medical schools to incentivize programs designed to increase number of primary care providers. <u>RESIDENT PHYSICIAN EXPANSION GRANT PROGRAM</u>- Creates a competitive grant program to encourage the creation of new GME positions. Program criteria include increasing residency positions for medical specialty shortages and MUAs. Requires THECB to report to Legislature, governor on program. <u>PELRP</u>- If funding remains after physicians practicing in HPSAs have been funded, allows physicians to participate in the PELRP without serving in a HPSA as long as they serve a certain number of Medicaid or TWHP patients. HHSC must verify this compliance and enter into a MOU with the physician. Requires HHSC to seek federal matching funds for PELRP program for providers treating Medicaid patients.	Centers with residency programs or centers planning to add a residency program. Rules will require reporting the number of Medicaid and CHIP patients served by physicians.
HB 2620 Tag: General	Author: Collier Sponsor: Deuell Effective Immediately Caption: Relating to the creation of a task force on domestic violence.	Creates a task force to examine issues related to domestic violence, including impacts on maternal and infant mortality and health, ways to include education on domestic violence into health care education and the coordination of health care services for mothers and children age 2 and under who have been victims of domestic violence. Task force will have 20 members, including "one representative from a statewide association of community health centers." Task force will report on their findings by 9/1/15 and is abolished on 1/1/16.	

HB 2627 Tag: Fraud and abuse	Author: Zedler Sponsor: Eltife Effective 9/1/13 Caption: Relating to complaints filed with the Texas Optometry Board.	Allows the Texas Optometry Board to create a remedial plan for providers that have been the subject of certain complaints.	

HB 3201 Tag: Licensure/ Fraud and Abuse	Author: Kolkhorst Sponsor: Nelson Effective 9/1/13 and 1/1/14 Caption: Relating to the practice of dentistry.	HB 3201 changes the State Board of Dental Examiner's investigation and complaint resolution procedures, paid for by an additional fee added to dental licenses and renewals. Section 1: Increases fees on dental licenses and renewals by $55 and puts the funds into the dental public assurance account, which will fund the dental board's enforcement program, including the expert panels described below. Section 2: Requires the dental board to inform dentists of allegations against them. Section 3: Prohibits members of the dental board from serving as expert witnesses. Section 4: Directs the dental board to collect information from dentists upon issuance or renewal of license on whether or not they practice at a dental service organization, whether they treat Medicaid/CHIP patients, and other specific information. Board must report to legislature every other year on the data collected and how it was used. Section 5: Requires the board to complete a preliminary investigation of a compliant within 60 days of receiving the complaint. They will then decide if the complaint warrants moving forward with an investigation. Section 6: Requires the board to create expert panels to assist with investigations of dentists and dental hygienists. Directs the board to promulgate rules related to the composition and duties of the panels. If a preliminary investigation (per Section 5) finds a license holder to be under the acceptable standard of care, the compliant will be reviewed by the expert panel. Provides details on expert panel processes for investigations. Section 7: Allows dental board to delegate authority to employees to issue licenses to qualified applicants. Section 8: Requires a parent or guardian of a child under 18 to be present in the room during dental treatment unless determined that the parent or guardian's presence would have an adverse impact on the treatment. Section 9: Allows the board to delegate to board employees the authority to dismiss or enter into an agreed settlement of complaint, only for complaints related to administrative issues and not patient care. In an informal settlement conference, notice of time, place and details of complaint must be given to license holder at least 45 days in advance. License holder must provide rebuttal at least 15 days before settlement date. If requested by license holder, board will record the informal settlement conference. Allows the board to issue a remedial plan for license holder involved in certain types of complaints. Remedial plan is public information and board may impose a fee to pay for it. Bill does not apply retroactively.	FQHCs do not fall under the definition of dental service organization, but entities that do will have to increase reporting to the state.

HB 3276 Tag: General	Author: Simmons Sponsor: Deuell Effective 9/1/13 Caption: Relating to the coverage by certain health benefit plans for the screening and treatment of autism spectrum disorder.	Current law requires insurers to cover expenses for enrollees diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. However, the law was unclear in regards to health plans covering screening for autism. HB 3276 requires health benefit plans to cover autism screenings at 18 and 24 months. Also allows for a person acting under the supervision of a qualified health care professional to treat a patient for autism. If the autism screening is above and beyond what is required by qualified health plans under the ACA, those plans are exempt from covering the screening.	
HB 3401 Tag: General	Author: Raymond Sponsor: Nelson Effective 9/1/13 Caption: Relating to a nutrition and wellness education program for certain recipients of certain state benefits.	Requires HHSC to work with community based organizations to encourage recipients of SNAP, TANF, and Medicaid to access free online health and wellness education, including information on the HHSC website, which encourages healthy living and active lifestyles. By 1/1/15, HHSC must report to legislature on number of people that accessed information and feedback from clients who used the information.	

TACHC Leadership Initiative

Team Composition

For the purposes of the project, TACHC defines the leadership "team" as the Chief Executive Officer or Executive Director, Chief Financial Officer, Clinic Manager (or similar position), and Chief Medical Officer. It is mandatory that at least these four individuals from your center participate in the program. However, many of the centers that have participated in the past have also included, at their discretion, their Human Resource Director, Nursing Director, Dental Director and/or other leaders in their center as part of their team. Unlike many other leadership programs that are available, the emphasis of the TACHC Executive Leadership Initiative is on developing the health center leadership "team" rather than solely focusing on individual leadership development for the Executive Director or CFO, for example. As a result, we hope to provide opportunities for participating centers to improve communication, cohesion and effectiveness of the individual participants as well as the core group that is responsible for leading their health center.

Project Design

The project design has evolved over the last 12 years based on feedback from past health center participants and strategies that have been particularly effective. The leadership program objectives are achieved through three face-to-face learning sessions, on-site leadership consulting, 2 webinars, supplemental reading materials, 360 Degree assessments of individual and team leadership skills, and the provision of leadership tools that that can be utilized in the day-to-day work at your community health center. Additionally, individual leadership plans and goals are developed for each of the participants.

Time Commitment

The time commitment and resources required of participating centers is minimal but it is critical that each of the participating team members actively participate and be committed to attend the learning sessions and coaching calls. There are three face-to-face meetings and six coaching calls. **The first face-to-face learning sessions will be held in Austin on July 19-20, 2013.** The other two face-to-face learning sessions will be held in November 2013 and February 2014. Locations for these two sessions will be determined by the location of the participating health centers. Typically, face-to-face sessions are held on Fridays and Saturdays to minimize time away from your health center. There will also be a follow up webinar in March 2014 and will require two hours with your center's team members.

Project Costs

TACHC receives funding from BPHC that subsidizes a majority of the costs associated with this program and will cover all consulting costs, speaker fees and material costs. TACHC will also pay $150 for four hotel rooms at the conference hotel for the participating teams for each of the three face-to-face learning sessions and up to $150 for four team members for reasonable travel costs associated with attending the three learning sessions. Thus, participating centers are only

required to pay a registration fee of $250 to cover the costs of food at the three, two day learning sessions and the second night of hotel expenses at the conference hotel. If a participating team has more than four leadership team members, the center will also be responsible for covering any hotel rooms and travel costs beyond the four rooms and travel costs paid for by TACHC.

Texas Higher Education Coordinating Board

STUDENT LOAN REPAYMENT PROGRAMS
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May 23, 2013

Dear Colleague:

The Physician Education Loan Repayment Program (PELRP) provides loan repayment funds to physicians who agree to practice in a Health Professional Shortage Area for at least four years. The PELRP was expanded substantially with the passage of HB 2154 by the 81st Texas Legislature. Changes to the tax code for smokeless tobacco created a revenue stream that supported this expansion, allowing up to $160,000 in student loan repayment over a period of four years for qualifying physicians.

The budget Senate Bill for 2014-2015 includes the funds that are allocated for the PELRP at a greatly increased amount over last session, as a result, the Coordinating Board will be able to: (1) disburse all third and fourth-year awards for current participants in the program and (2) enroll new participants into the program. We must identify qualifying physicians as soon as possible to maximize the use of any appropriated funds.

The Coordinating Board is now accepting applications for enrollment in the program. The application may be downloaded from the program web page, which can be selected at www.thecb.state.tx.us/lrp. The priority deadline for the initial group of new applications is **August 31, 2013**. Application will be ranked after the priority deadline, according to current criteria established in the attached administrative rule.

Any programmatic changes resulting from the passage of new legislation will be updated on the PELRP web page. If you have any questions, please contact me, Stacy Johnson, or Tamika Lighten by phone at (512)427-6366, (512)427-6357, or (512)427-6492 or by e-mail at loanrepaymentprograms@thecb.state.tx.us.

The Coordinating Board would very much appreciate your passing along this information to all eligible physicians and others who are in a position to reach physicians who may be interested in enrolling in the PELRP.

Sincerely,

Lesa Moeller

Director, Loan Repayment Programs
DCT/tl
Enclosure

Texas Administrative Code: Chapter 21, Subchapter J
Physician Education Loan Repayment Program

21.257. Application Ranking Criteria.

If there are not sufficient funds to award loan repayment assistance for all eligible physicians whose applications are received by the stated deadline, applications shall be ranked according to the following criteria, in priority order:

(1) renewal applications, with first priority assigned to those for primary care;

(2) applications from primary care physicians practicing in rural geographic whole-county HPSAs and applications from physicians practicing in Federally Qualified Health Centers or practice sites that accept payments on a sliding fee scale and follow a policy of providing health care to all who present for care;

(3) HPSA score for applicant practice location;

(4) the first ten applications received each year from eligible physicians serving persons committed to a secure correctional facility operated by or under contract with the Texas Youth Commission and its successor or persons confined to a secure correctional facility operated by or under contract with any division of the Texas Department of Criminal Justice.